(q) Hospitals with 100 or fewer licensed beds. The policies in this subsection apply only to hospital fiscal years beginning on or after September 1, 1989, and are applicable only to hospitals with 100 or fewer licensed bed at the beginning of the hospital's fiscal year. At tentative cost settlement of the hospital's fiscal year (with subsequent adjustment at final cost settlement, if applicable), the state agency or its designee determines what the amount of reimbursement during the fiscal year would have been if the state agency or its designee reimbursed the hospital under the Medicare principles of reasonable cost. This determination is made without imposing the TEFRA rate of increase limits. If the amount of costs under the Medicare principles of reasonable cost is greater than the amount of reimbursement received by the hospital under the prospective payment system, the state agency or its designee reimburses the difference to the hospital.

(r) Reimbursement to out-of-state children's hospitals. For admissions on or after September 1, 1991, the standard dollar amount for out-of-state children's hospitals is calculated as specified in this subsection. The state agency or its designee calculates the overall average cost per discharge for in-state children's hospitals based on tentative or final settlement of cost reporting periods ending in calendar year 1990. The overall average cost per discharge is adjusted for intensity of service by dividing it by the average relative weight for all admissions from in-state children's hospitals during state fiscal year 1990 (September 1, 1989 - August 31, 1990). The adjusted cost per discharge is updated each year as additional final settlements are completed using the time frames described in subsection (n) of this section and by applying the cost-of-living index described in subsection (n) of this section. The resulting product is the standard dollar amount to be used for payment of claims as described in subsection (e) of this section. The state agency or its designee selects a new cost reporting period and admissions period from the in-state children's hospitals at least every three years for the purpose of calculating the standard dollar amount for out-of-state children's hospitals.

(s) Reimbursement of inpatient direct graduate medical education (GME) costs. The Medicaid-allowable inpatient direct graduate medical education payment, as specified under current Medicare methods and procedures, is calculated for each hospital having inpatient direct graduate medical education costs on its tentative or final audited cost report. Those inpatient direct medical education costs are removed from the calculation of the interim rate. Only hospitals showing medical education reimbursement on t heir cost report receive GME interim payments.The interim rate is described in subsection (b)(7) of this section and is used in the calculation of the provider's standard dollar amount described in subsection (c) of this section.

Those allowable inpatient direct graduate medical education costs for services delivered to ~~Medicaid-eligible~~ patients with inpatient admission dates on or after September 1, 1997, will be subject to the reimbursement and settlement provisions as described in this subsection.

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SUPERSEDES: TN - 93-14

Providers with Medicaid-allowable inpatient direct graduate medical education costs as described in this subsection will receive an interim monthly payment based upon one-twelfth of their inpatient direct graduate medical education cost from their most recent tentative or final audited cost report. The interim payment amount as described in this subsection will not be updated during the state fiscal year to reflect new tentative or final cost report settlements. These payments are subject to settlement (actual vs. Estimated number of FTEs) at both tentative and final audit for provider cost reporting periods covering the state fiscal year.

No Medicaid inpatient direct graduate medical education cost settlement provisions are applied to inpatient hospital admissions prior to September 1, 1997.

2. Effective for all accounting periods beginning on or after January 1, 1982, Title XIX providers will no longer be allowed to carry forward those unreimbursed costs attributed to lower of cost or charge limitations authorized by 42 CFR 413.13.

3. Obligations to provide free care made by a hospital under Hill Burton or any other arrangement as a condition to secure grants or loans are not recognized as a cost under the Texas Medical Assistance Program.

4. The contents of paragraphs 1 through 3 do not describe the amount, duration or scope of services provided to eligible recipients under the Texas Medical Assistance Program.

STATE Texas
DATE REC'D 2-9-94
DATE APPV'D 4-6-94
DATE EFF 2-1-94
HCFA 179 94-06
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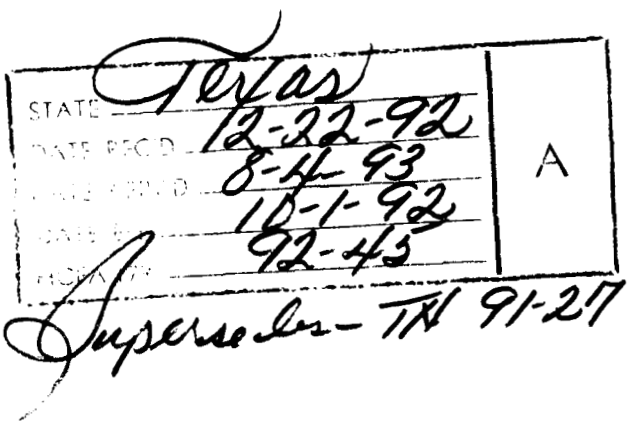
Supersedes TN 91-27

EPSDT DIAGNOSTIC AND TREATMENT SERVICES NOT OTHERWISE COVERED UNDER THE STATE PLAN

Inpatient psychiatric hospital services furnished to EPSDT recipients. The psychiatric hospital must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The single state agency or its designee reimburses psychiatric hospitals using Medicare principles of reasonable cost reimbursement found at 42 CFR 413, but without applying the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) rate of increase limits. The single state agency or its designee establishes interim payment rates. EPSDT recipients will be given the free choice of qualified providers and the requirements of 42 CFR 441 Subpart D will be met.

Except for payment as described in this attachment for inpatient hospital services, payment for authorized medically necessary services required to diagnose and treat a condition found on EPSDT medical screening will be based on existing Medicare and Medicaid reimbursement methodologies.



State of Texas

Attachment 4.19-A
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Reimbursement Methodology: The single state agency or its designee determines reimbursement rates at least annually. Effective for services provided on and after November 16, 1994, a state-wide prospective rate for inpatient hospital services provided to individuals age 65 years and older in institutions for mental disease (hereafter referred to as "IMD services") will be available to all qualified and enrolled providers. This rate is inclusive of all costs allowable under Medicare payment principles.

Initial Rate Period

The initial rate period is defined as November 16, 1994, through April 30, 1996. The reimbursement rate for this period is determined from Medicare cost reports for state operated hospitals which provided IMD services between September 1, 1993 and August 31, 1994. The state will ask for cost reports from all providers enrolling in the IMD program covered by the State Plan to ensure that the rates set in the initial rate period are adequate to cover economic and efficient providers in the data base. All facilities that enroll in subsequent periods will be added to the array for future per diem rate determination. The Medicare cost reports are reviewed by the single state agency or its designee to assure that the costs used for calculating each hospital's average per diem cost for IMD services are allowable under Medicare payment principles and are only those costs incurred by the hospital for care and treatment provided to persons 65 years and older and occupying a Medicare-certified bed. Using these Medicare cost reports, each hospital's average per diem cost for IMD services is calculated.

The single state agency or its designee then adjusts each hospital's average per diem cost for IMD services to the initial rate period by applying a cost-of-living index. For this initial rate period, the index used to update the average per diem cost of each hospital is the Health Care Financing Administration's (HCFA) Market Basket Forecast Excluded Hospital Input Price Index (as reported in the Dallas Regional Medical Services Letter No. 95-015). Due to the length of the initial rate period, the percentages by which the average per diem costs are adjusted are prorated for the initial rate period by taking 1/12 of the forecast for Calendar Year 1994 plus 12/12 of the forecast for Calendar Year 1995 plus 4/12 of the forecast for Calendar Year 1996. After adjusting the average per diem cost for each hospital, the average per diem costs for all hospitals in the pool are arrayed from high to low. The median (50th percentile) hospital's average per diem cost is selected as the prospective rate for the initial rate period.

STATE Texas
DATE REC'D DEC 27 1994
DATE APPVD AUG 24 1995
DATE EFF NOV 16 1994
HCFA 179 94-30

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SUPERSEDES: NONE - NEW PAGE

Future Rate Periods

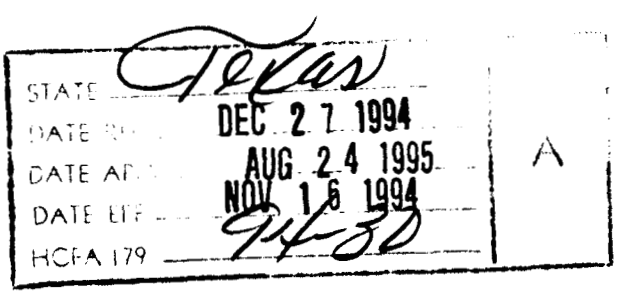
Beginning in 1996, the rate period begins on May 1 and ends on April 30 of the following year. Annually, each participating hospital (hereafter referred to as an "IMD provider") is required to submit to the single state agency or its designee a copy of its Medicare cost report for its most recent fiscal year ending prior to September 1. Each IMD provider is required to identify in its cost report as a subunit those Medicare-certified units on which IMD services were provided (hereafter referred to as "IMD units"). The Medicare cost reports are reviewed by the single state agency or its designee to assure that the costs to be used for calculating each provider's average per diem cost for IMD services are allowable under Medicare payment principles and are only those costs incurred for care and treatment provided to persons 65 years of age and older and occupying a Medicare-certified bed.

Upon completion of the reviews of cost reports, and prior to calculating average per diem costs for each provider, both cost reports and prior payment histories are reviewed. To insure the integrity of the data and avoid bias in the resulting rate due to low volume and other inefficiencies, providers will be eliminated from the data base for any one or more of the following reasons: being in operation fewer than 90 calendar days during the previous cost reporting period; having an occupancy rate on its IMD units of less than 90% for 50% or more of the days covered during the previous cost reporting period; or individually accounting for fewer than 5% of the total days of care reimbursed by Medicaid as IMD services during the previous cost reporting period.

For those IMD providers left in the data base after the review of cost reports and deletion for the above-named reasons, the single state agency or its designee, using the Medicare cost report, calculates for each IMD provider an average per diem cost for IMD services (the "historical per diem cost").

The single state agency or its designee then adjusts each IMD provider's historical per diem cost for IMD services to the future rate period by applying a cost-of-living index. The index used to adjust the per diem cost of each IMD provider is the Health Care Financing Administration's (HCFA) Market Basket Forecast Excluded Hospital Input Price Index (as reported to the States in the Dallas Regional Medical Services Letter for the federal fiscal quarter ending in December of the year preceding the future rate period). The percentage used for adjustments to each IMD provider's average per diem cost is prorated for the future rate period, using 2/3 of the forecast for the calendar year in which the rate period begins (May through December) plus 1/3 of the forecast for the next calendar year (January through April).

After adjusting the average per diem cost for each IMD provider, the average per diem costs of all IMD providers in the pool are arrayed from high to low. The median (50th percentile) IMD provider's average per diem cost is selected as the prospective rate for the future rate period. Should the 50th percentile fall between providers, the immediately higher average per diem cost will be selected as the reimbursement rate for the next rate period. All participating providers will be paid this rate for each day during the next rate period that IMD services are provided to an eligible individual.



SUPERSEDES: NONE - NEW PAGE

State of Texas Disproportionate Share Hospital Reimbursement Program
for Hospitals Other Than State-Owned Teaching Hospitals

The single state agency has developed a method of identifying Medicaid disproportionate share hospitals, excluding state-owned teaching hospitals which qualify for the disproportionate share hospital program for state-owned teaching hospitals, and formulas to reimburse them for their cost of treating indigent patients.

(a) Prior to the beginning of each state fiscal year, which starts September 1, the single state agency surveys Texas' Medicaid hospitals to determine which hospitals meet the state's conditions of participation.

(1) The state identifies and reimburses those hospitals that provide a disproportionate share of inpatient care to indigent patients. Qualifying hospitals return completed surveys, giving evidence of nonrestrictive eligibility policies for state approval. A qualifying hospital must submit its criteria and procedures for identifying patients who qualify for charity care to the state for approval. The policy for charity care must be posted prominently, in English and Spanish, and all patients must be advised of the availability of charity care and the procedures for applying.

(2) Each hospital must have a Medicaid inpatient utilization rate as defined in §1923(b)(2), at a minimum, of one percent in accordance with §§1923(d)(3) and 1923(e)(2)(C) of the Social Security Act.

(3) To qualify for disproportionate share payments, each hospital must have at least two physicians (M.D. or D.O.), with staff privileges at the hospital, who have agreed to provide nonemergency obstetrical services to Medicaid clients. The two-physician requirement does not apply to hospitals whose inpatients are predominantly under 18 years old or that did not offer nonemergency obstetrical services to the general population as of December 22, 1987.

(b) For purposes of this state plan:

(1) Total Medicaid inpatient days means the total number of billed Title XIX inpatient days based on the latest available state fiscal year data for patients eligible for Title XIX benefits. Total Medicaid inpatient days includes days that were denied payment for reasons other than eligibility. Included are inpatient days of care provided to patients eligible for Medicaid at the time the service was provided, regardless of whether the claim was paid. Examples of these denied claims include, but are not limited to, claims for patients whose spell of illness limits are exhausted, or claims that were filed late. The term excludes days attributable to Medicaid patients between the ages of 21 and 65 who live in an institution for mental diseases. The term includes days attributable to individuals eligible for Medicaid in other states.